		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032128

Facility Name: Carolyn Smith House

Address: 910 17th Street (Number) Charleston (City) 61920 (Zip Code)

County: Coles

Telephone Number: (217) 345-2922 **Fax #** (217) 398-0944

IDPA ID Number: 37-1200620002

Date of Initial License for Current Owners: 04/16/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sherry Newton **Telephone Number:** (217) 398-0754

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/03 to 09/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Sherry Newton
(Title) Chief Executive Officer

Paid Preparer

(Signed) See Attached Compilation Report (Date)
(Print Name and Title) James B. Eisenmenger, MS, CPA — Member
(Firm Name & Address) Martin, Hood, Friese & Associates, LLC — 2507 S. Neil Street, Champaign, IL 61820
(Telephone) (217) 351-2000 Fax # (217) 351-7726

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,369			5,369	13
14	TOTALS	5,369			5,369	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.68%

D. How many bed-hold days during this year were paid by Public Aid?
196 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/16/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/16/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/04 Fiscal Year: 09/30/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House # 0032128 **Report Period Beginning:** 10/01/03 **Ending:** 09/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	35,595	80	966	36,641		36,641	420	37,061			1
2	Food Purchase		28,074		28,074		28,074	1,329	29,403			2
3	Housekeeping	25,200	4,954		30,154		30,154	11	30,165			3
4	Laundry	13,826	170		13,996		13,996		13,996			4
5	Heat and Other Utilities			14,899	14,899		14,899	1,550	16,449			5
6	Maintenance			23,501	23,501		23,501	12,847	36,348			6
7	Other (specify):*											7
8	**TOTAL General Services**	74,621	33,278	39,366	147,265		147,265	16,157	163,422			8
	B. Health Care and Programs											
9	Medical Director		4,963	3,162	8,125		8,125	(163)	7,962			9
10	Nursing and Medical Records	58,432		27,879	86,311		86,311	1,385	87,696			10
10a	Therapy											10a
11	Activities	20,739	863		21,602		21,602	1	21,603			11
12	Social Services			4,200	4,200		4,200	(4,170)	30			12
13	Nurse Aide Training	13,651			13,651		13,651		13,651			13
14	Program Transportation			1,931	1,931		1,931	2,177	4,108			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	92,822	5,826	37,172	135,820		135,820	(770)	135,050			16
	C. General Administration											
17	Administrative	28,375		55,514	83,889		83,889	(26,852)	57,037			17
18	Directors Fees			1,215	1,215		1,215		1,215			18
19	Professional Services			5,211	5,211		5,211	2,144	7,355			19
20	Dues, Fees, Subscriptions & Promotions			4,415	4,415		4,415	740	5,155			20
21	Clerical & General Office Expenses	13,826	2,174	13,766	29,766		29,766	7,123	36,889			21
22	Employee Benefits & Payroll Taxes			66,941	66,941		66,941	11,995	78,936			22
23	Inservice Training & Education			319	319		319	53	372			23
24	Travel and Seminar							792	792			24
25	Other Admin. Staff Transportation			828	828		828	1,404	2,232			25
26	Insurance-Prop.Liab.Malpractice			5,351	5,351		5,351	2,925	8,276			26
27	Other (specify):*											27
28	**TOTAL General Administration**	42,201	2,174	153,560	197,935		197,935	324	198,259			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	209,644	41,278	230,098	481,020		481,020	15,711	496,731			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Carolyn Smith House #0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			14,213	14,213		14,213	11,337	25,550			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,881	1,881		1,881	7,538	9,419			32
33	Real Estate Taxes			4,506	4,506		4,506	1,487	5,993			33
34	Rent-Facility & Grounds			47,400	47,400		47,400	933	48,333			34
35	Rent-Equipment & Vehicles			1,248	1,248		1,248	374	1,622			35
36	Other (specify):*											36
37	**TOTAL Ownership**			69,248	69,248		69,248	21,669	90,917			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,805	40,805		40,805		40,805			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			40,805	40,805		40,805		40,805			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	209,644	41,278	340,151	591,073		591,073	37,380	628,453			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule **Schedule VIII**	37,380		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 37,380		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 37,380		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Carolyn Smith House

ID# 0032128

Report Period Beginning: 10/01/03

Ending: 09/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Carolyn Smith House # 0032128 **Report Period Beginning:** 10/01/03 **Ending:** 09/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Carolyn Smith House **#** 0032128 **Report Period Beginning:** 10/01/03 **Ending:** 09/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule VII C.		See Attached Schedule		Health Services Cons.	Champaign, IL	Consulting
				Cobblestone Rehab.	Champaign, IL	Therapy
				Specialized Developme	Champaign, IL	Long Term Care
				Residential Developers	Champaign, IL	Long Term Care
				MBD, LLC	Champaign, IL	Rental Real Estate
				P&L Rentals, LLC	Champaign, IL	Rental Real Estate

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See Schedule VIII	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Alan Ryle	President	Administrative	60.00	All related party wages are allocations			Administrative	$ 3,534	17-7	1
2	Alan Ryle	President	Administrative	60.00	from HSC. See attached allocation			Directors Fees	405	18-7	2
3	Lynn Ryle	Vice President	Administrative	0.00	spreadsheet and explanation. These			Administrative	2,809	17-7	3
4	Lynn Ryle	Vice President	Administrative	0.00	individuals receive no compensation from			Directors Fees	405	18-7	4
5	Patti Hood			40.00	entities other than HSC.				405	18-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 7,558		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Office Management - division of TRD, Inc.
Street Address: P.O. Box 1044
City / State / Zip Code: Champaign, IL 61824
Phone Number: (217) 398-0754
Fax Number: (217) 398-0944

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3		Office Management central office charges now included in HSC allocation on pages 8A and 8B.								3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Health Services Consultants, Inc.
Street Address: P.O. Box 1044
City / State / Zip Code: Champaign, IL 61824
Phone Number: (217) 398-0754
Fax Number: (217) 398-0944

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing	Reverse expenses for actual amounts paid and accrued to			$	$		$ (18,873)	1
2	12	Social	HSC for services provided in order to allocate HSC's						(4,200)	2
3	17	Administrative	actual expenses						(55,514)	3
4	21	Clerical							(11,250)	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13	1	Dietary	Beds	537	207	5,440	5,440	16	420	13
14	2	Food Purchases	Beds	537	207			16		14
15	3	Housekeeping	Beds	537	207	361		16	11	15
16	5	Heat & Utilities	Beds	537	207	51,888		16	1,546	16
17	6	Maintenance	Beds	537	207	195,185	115,781	16	11,226	17
18	9	Medical Director	Beds	537	207			16		18
19	10	Nursing	Beds	537	207	365,135	295,893	16	20,258	19
20	11	Activities	Beds	537	207	30		16	1	20
21	12	Social	Beds	537	207	1,000		16	30	21
22	13	Nurse Training	Beds	537	207			16		22
23	14	Program Transportation	Beds	537	207	52,902		16	1,576	23
24	17	Administrative	Beds	537	207	685,209	685,209	16	28,662	24
25	TOTALS					$ 1,357,150	$ 1,102,323		$ (26,107)	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Health Services Consultants, Inc.
Street Address: P.O. Box 1044
City / State / Zip Code: Champaign, IL 61824
Phone Number: (217) 398-0754
Fax Number: (217) 398-0944

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	18	Director's Fees	Beds	537	207			16		2
3	19	Professional Fees	Beds	537	207	71,421		16	2,128	3
4	20	Dues & Subscriptions	Beds	537	207	14,287		16	426	4
5	21	Clerical	Beds	537	207	509,778	342,653	16	16,200	5
6	22	P/R Taxes & Benefits	Beds	537	207	476,292		16	12,666	6
7	23	Inservice	Beds	537	207	1,637		16	49	7
8	24	Travel & Seminar	Beds	537	207	22,776		16	679	8
9	25	Administrative Transportation	Beds	537	207	47,127		16	1,404	9
10	26	Insurance	Beds	537	207	68,180		16	2,031	10
11	30	Depreciation	Beds	537	207	357,978		16	10,666	11
12	32	Interest	Beds	537	207	210,642		16	6,276	12
13	33	Real Estate Tax	Beds	537	207	49,900		16	1,487	13
14	34	Building Lease	Beds	537	207			16		14
15	35	Equipment Lease	Beds	537	207	11,418		16	340	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,198,586	$ 1,444,976		$ 28,245	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Developmental Foundations, Inc.
Street Address: P.O. Box 1044
City / State / Zip Code: Champaign, IL 61824
Phone Number: (217) 398-0754
Fax Number: (217) 398-0944

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	79	5	$ 1	$	16	$	1
2	2	Food Purchases	Beds	79	5	6,564		16	1,329	2
3	5	Utilities	Beds	79	5	21		16	4	3
4	6	Maintenance	Beds	79	5	8,004		16	1,621	4
5	9	Medical Director	Beds	79	5	(804)		16	(163)	5
6	14	Program Transportation	Beds	79	5	2,965		16	601	6
7	19	Professional Services	Beds	79	5	79		16	16	7
8	20	Fees, Subs & Promos	Beds	79	5	1,548		16	314	8
9	21	Clerical & Gen Office	Beds	79	5	10,728	666	16	2,173	9
10	22	Employee Ben. & P/R Tax	Beds	79	5	(3,314)		16	(671)	10
11	23	Inservice Training & Educ	Beds	79	5	22		16	4	11
12	24	Travel & Seminars	Beds	79	5	558		16	113	12
13	26	Insurance	Beds	79	5	4,415		16	894	13
14	30	Depreciation	Beds	79	5	3,315		16	671	14
15	32	Interest	Beds	79	5	6,231		16	1,262	15
16	34	Building Lease	Beds	79	5	4,608		16	933	16
17	35	Equipment Lease	Beds	79	5	170		16	34	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 45,111	$ 666		$ 9,135	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC		X	Vehicle	$671.00	11/27/01	$ 24,188	$ 2,034	12/11/04	zero	$	1
2	Schedule VIII Allocations		X								7,538	2
3												3
4												4
5												5
	Working Capital											
6	Busey Bank		X	Line of Credit	N/A	N/A	N/A		N/A		1,881	6
7												7
8												8
9	TOTAL Facility Related				$671.00		$ 24,188	$ 2,034			$ 9,419	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 24,188	$ 2,034			$ 9,419	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$ 3,246	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 4,112	2
3. Under or (over) accrual (line 2 minus line 1).	$ 866	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 3,640	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 4,506	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	4,214	8
2000	4,293	9
2001	3,806	10
2002	4,052	11
2003	4,112	12

$4,853 (estimated 2004 tax) x 9/12 = $3,640

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carolyn Smith House COUNTY Coles

FACILITY IDPH LICENSE NUMBER 0032128

CONTACT PERSON REGARDING THIS REPORT Sherry Newton

TELEPHONE (217) 398-0754 FAX #: (217) 398-0944

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-1-04352-000	Facility	$ 3,868.00	$ 3,868.00
2.	02-1-04351-000	Facility	$ 244.00	$ 244.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 4,112.00	$ 4,112.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,200 B. General Construction Type: Exterior Wood Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements			1993	12,864	372	34	372		4,387	9
10	Leasehold Improvements			1995	5,656	209	27	209		1,966	10
11	Window Treatments			1997	7,428	275	27	275		2,245	11
12	Flooring			1998	6,670	247	27	247		1,666	12
13	Flooring			1998	2,030	75	27	75		494	13
14	Alarm System Upgrade			1998	4,356	161	27	161		1,026	14
15	Alarm System Upgrade			1999	843	21	40	21		139	15
16	Furnace			2001	1,650	165	10	165		608	16
17	Fire Alarm System			2003	4,400	160	27.5	160		234	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 45,897	$ 1,687		$ 1,687	$	$ 12,765	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 23,570	$ 2,971	$ 2,971	$	7/10	$ 9,813	71
72	Current Year Purchases	577	76	76		7	76	72
73	Fully Depreciated Assets	5,933					5,933	73
74								74
75	TOTALS	$ 30,080	$ 3,047	$ 3,047	$		$ 15,822	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1999 GMC Safari	1999	$ 18,832	$ 3,296	$ 3,296	$	5	$ 18,832	76
77	Administrative Transportatio	Pontiac Grand Am	1999	9,633	1,766	1,766		5	9,553	77
78	Patient Transportation	2002 GMC Safari	2001	22,089	4,417	4,417		5	12,517	78
79										79
80	TOTALS			$ 50,554	$ 9,479	$ 9,479	$		$ 40,902	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 126,531	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 14,213	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 14,213	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 69,489	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Milestone Midwest, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1987	15		$ 47,400	15	15	3
4	Additions	1993	1					4
5								5
6								6
7	TOTAL		16		$ 47,400 **			7

8. List separately any amortization of lease expense included on page 4, line 34. None
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	N/A - month to	$
13.	month lease	$
14.		$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 1,248 Description: Copier Lease
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)		4,550		4,550
4	Clinical Wages	(b)		9,101		9,101
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 13,651	$	$ 13,651
10	SUM OF line 9, col. 1 and 2	(e)	$ 13,651			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	12

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House # 0032128 **Report Period Beginning:** 10/01/03 **Ending:** 09/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 09/30/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	123,158		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 123,158	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	45,897		15
16	Equipment, at Historical Cost	80,634		16
17	Accumulated Depreciation (book methods)	(69,489)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 57,042	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 180,200	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	6,453		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,640		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 10,093	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,034		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,034	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 12,127	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 168,073	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 180,200	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 155,977	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 155,977	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	75,093	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 75,093	17
	B. Transfers (Itemize):		
18	**Transfers (to) from Developmental Foundations, Inc.**	(62,997)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (62,997)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 168,073	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 666,166	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 666,166	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 666,166	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	147,265	31
32	Health Care	135,820	32
33	General Administration	197,935	33
	B. Capital Expense		
34	Ownership	69,248	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	40,805	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 591,073	40
41	**Income before Income Taxes (line 30 minus line 40)****	75,093	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 75,093	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.** **Tax Return is on a 12/31 fiscal year.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	1,440	1,440	13,651	9.48	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,190	2,190	20,739	9.47	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,977	2,051	18,312	8.93	14
15	Cook Helpers/Assistants	1,825	1,825	17,283	9.47	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	2,577	2,745	25,200	9.18	18
19	Laundry	1,460	1,460	13,826	9.47	19
20	Administrator	2,036	2,183	28,375	13.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,460	1,460	13,826	9.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	5,431	6,167	58,432	9.47	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,396	21,521	$ 209,644 *	$ 9.74	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 966	1-3	35
36	Medical Director		3,152	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant		18,305	10-3	38
39	Pharmacist Consultant		196	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant		4,587	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		3,201	10-3	43
44	Activity Consultant				44
45	Social Service Consultant		4,200	12-3	45
46	Other(specify)				46
47	Psychologist		1,320	10-3	47
48	Dentist		270	10-3	48
49	TOTAL (lines 35 - 48)		$ 36,197		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
J. Rieman (75% Other Homes)	Admin	None	$ 8,975
C. Rabb	50% Admin	None	608
R. Wojtysiak	50% Admin	None	13,656
A. Ybarra	50% Admin	None	5,137
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 28,375

B. Administrative - Other

Description	Amount
Management Support & Consulting	$ 55,514
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 55,514

C. Professional Services

Vendor/Payee	Type	Amount
Martin, Hood, Friese & Assoc.	Accounting	$ 2,998
Thomas, Mamer & Haughey	Legal	1,606
Various	Various	607
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 5,211

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 2,556
Unemployment Compensation Insurance	3,107
FICA Taxes	16,038
Employee Health Insurance	38,964
Employee Meals	5,264
Illinois Municipal Retirement Fund (IMRF)*	
Other	1,012
Schedule VIII Allocation	11,995
TOTAL (agree to Schedule V, line 22, col.8)	$ 78,936

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,161
Health Care Worker Background Check	
(Indicate # of checks performed 5)	82
Dues & Subscriptions	3,172
Contributions	
Schedule VIII Allocation	740
Less: Contributions	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,155

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Schedule VIII Allocation	792
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 792

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Carolyn Smith House # 0032128 Report Period Beginning: 10/01/03 Ending: 09/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Carolyn Smith House # 0032128 **Report Period Beginning:** 10/01/03 **Ending:** 09/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IARF - $956**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **40,805**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **5,264** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **Attached**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **None**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **None**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.